

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015153

STATE FILE NUMBER

2 3416

FILED MAY 7 1959 Registration District No. Primary Registration District No. Registrar No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>East St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Firmin DeLoge</u>		d. STREET ADDRESS (If outside, give location) <u>1200 North Third Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Genevieve Magdalene HRASKY</u>		4. DATE OF DEATH Month Day Year <u>April 4 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		11. BIRTHPLACE (City and state or country) <u>Liplovljani, Yugo-Slavia U. S. A.</u>	
13a. FATHER'S NAME <u>Lambert Holberger</u>		14. NAME OF HUSBAND OR WIFE <u>Alois Hrasky, Sr.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT Address <u>Mrs. Alvina Vlcek - E. St. Louis, Ill.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic granulocytic leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>19 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Dec. 11, 1958</u> to <u>Apr. 4, 1959</u> and last saw her alive on <u>April 2, 1959</u> Death occurred at <u>12:01 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>G.O. Broun, Jr., M.D.</u> (Degree or title)		22b. ADDRESS <u>1325 South Grand Blvd.</u>	
22c. DATE SIGNED <u>4/4/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/7/59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Carmel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Belleville, Illinois</u>	
24. FUNERAL DIRECTOR <u>E. St. Louis, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>APR 6 '59</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Not Embalmed, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed Joseph H. Smith

Licensed Embalmer No. 107

P. O. Address C. H. Smith

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.